UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
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ARLINGTON, TEXAS 76011-8064

AUG 15 1997

Otto L. Maynard, President and
Chief Executive Officer
Wolf Creek Nuclear Operating Corporation
P.O. Box 411
Burlington, Kansas 66839

SUBJECT: NRC INSPECTION REPORT 50-482/97-10

Dear Mr. Maynard:

Thank you for your letter of August 8, 1997, in response to our letter and Notice of Violation dated July 10, 1997. We have reviewed your reply and find it responsive to the concerns raised in our Notice of Violation. We will review the implementation of your corrective actions during a future inspection to determine that full compliance has been achieved and will be maintained.

Sincerely,

Thomas P. Gwynn, Director
Division of Reactor Projects

Docket No.: 50-482
License No.: NPF-42

cc:
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bcc to DCD (IE01)

bcc distrib. by RIV:

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DRP Director	SRI (Callaway, RIV)
Branch Chief (DRP/B)	DRS-PSB
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Branch Chief (DRP/TSS)	RIV File

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WOLF CREEK
NUCLEAR OPERATING CORPORATION

Gary D. Boyer
Chief Administrative
Officer

August 8, 1997
CO 97-0056

U. S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Mail Station P1-137
Washington, D. C. 20555

Reference: Letter dated July 6, 1997, from T. P. Gwynn, NRC, to O. L. Maynard, WCNOC

Subject: Docket No. 50-482: Response to Notice of Violations 50-482/9710-01, -02, -03, and -06

Gentlemen:

This letter transmits Wolf Creek Nuclear Operating Corporation's (WCNOC) response to Notice of Violations 50-482/9710-01, -02, -03, and -06. Violation 9710-01 cites a failure to have instructions or procedures to ensure that licensed operators had appropriate corrective lenses available for use with self-contained breathing apparatus. Violation 9710-02 addresses examples of workers performing safety-related work in excess of the Technical Specification 6.2.2.f work hour limits. Violation 9710-03 identifies violations of Technical Specification Surveillance requirement 4.5.2.c.2. Violation 9710-06 identified two incidents of personnel entering the Radiation Control Area (RCA) with incorrect dosimetry.

WCNOC's response to these violations is provided in the attachment. If you have any questions regarding this response, please contact me at (316) 364-8831, extension 4450, or Mr. Richard D. Flannigan at extension 4500.

Very truly yours,

Gary D. Boyer

GDB/jad

Attachment

cc: W. D. Johnson (NRC), w/a
E. W. Merschoff (NRC), w/a
J. F. Ringwald (NRC), w/a
J. C. Stone (NRC), w/a

97-1641

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Violation 50-482/9710-01:

"10 CFR Part 50, Appendix B, Criterion V, states, in part, ... 'activities affecting quality shall be prescribed by documented instructions, procedures, or drawings of a type appropriate to the circumstances ... Instructions, procedures, or drawings shall include appropriate quantitative or qualitative acceptance criteria for determining that important activities have been satisfactorily accomplished.'

Contrary to the above, on May 8, 1997, the NRC inspectors discovered that there were no instructions or procedures to ensure that all licensed operators, who were required to wear corrective lenses as a condition of their individual licenses, had corrective lenses of the appropriate type available should these individuals be required to wear self-contained breathing apparatus while performing licensed duties."

Reason for Violation:

Operators required to wear corrective lenses by their NRC license ensure that they have and wear their normal eye wear while standing watch in the control room. In the past, all Operations personnel requiring SCBA glasses were supplied with a pair, and the glasses were kept in a location within or close to the control room. The necessity to maintain SCBA glasses readily available did not remain prominent in the operators' awareness, due to the lack of a cyclic reminder.

The purchase of a new style SCBA required all operators that needed corrective lenses to arrange for new SCBA glasses. Twenty-one of twenty-four active licenses requiring corrective lenses did not have glasses that fit the new SCBAs. The three that did have glasses were new licenses that had also just finished SCBA refresher class on the new SCBAs.

The root cause of this event was the lack of administrative controls to ensure SCBA compatible corrective lenses were readily available for licensed operators required to have them.

Corrective Steps Taken and Results Achieved:

- All active licenses were reviewed for restrictions. A folder listing each crew member's restriction, if any, was compiled. The Shift Supervisors reviewed this list prior to assuming the watch, to insure proper crew manning. This review of restrictions was implemented June 27, 1997.

- SCBA eyeglasses were acquired for those active licensed operators who are required to have SCBA compatible eyeglasses, but did not have them. These glasses are stored in a location which makes them readily available, should the need to don SCBAs in the control room arise.

Corrective Steps That Will Be Taken And The Date When Full Compliance Will Be Achieved:

- A procedure to track and monitor adherence of Licensed Operator restrictions is being developed and will be issued by August 29, 1997.

- A reminder of the requirement that some licensed operators are required to have appropriate eye wear to wear SCBAs in the control room is being added to the training material involving the donning of SCBAs. This will be incorporated by August 29,1997.

Violation 50-482/9710-02:

" 10 CFR Part 50, Appendix B, Criterion XVI, specifies that measures shall be established to assure that conditions adverse to quality, such as failures, malfunctions, deficiencies, or deviations are promptly identified and corrected. In the case of significant conditions adverse to quality, the measures shall assure that the cause of the condition is determined and corrective action taken to preclude recurrence.

Contrary to the above, as of May 24, 1997, a significant condition adverse to quality - repetitive examples of workers engaging in safety-related work in excess of the Technical Specification 6.2.2.f limits without the review and approval of management - was identified, but actions were not taken to determine and correct the cause of the repeat of these violations. Specifically, the licensee responded to Violation B of NRC Inspection Report 50-482/94-12, but the corrective actions were inadequate to preclude recurrence, and this condition was not recognized until questioned by the NRC inspectors."

Reason for Violation:

Two distinct problems were identified.

Failures to get authorization prior to exceeding work hour limits

The root cause was less than adequate supervision. Contributing factors were poor communication, lack of reinforcement of management expectations, and a poorly written procedure.

Failure of previous corrective actions and failure to recognize problem recurrence

Management failed to recognize that past corrective actions were ineffective at preventing problem recurrences. The cause of this condition was inadequate management oversight of the corrective action program. This condition was identified previous to this violation. Procedure AP 28A-001, "Performance Improvement Request" was revised to improve root cause and corrective action credibility and depth. The Corrective Action Review Board was established. Performance Improvement International is currently providing root cause and human error reduction training to personnel. No additional corrective actions are planned for this condition.

Management also failed to identify an adverse trend of recurring problems with unauthorized deviations from the work hour guidelines, and that this condition was generic and pertained to several work groups. Problems in trending and identifying generic implications were corrective action program weaknesses identified previous to this violation. To correct the concern, a new procedure, AI 28E-005, "Guidelines for PIR Trend Coding", was issued, to help develop common cause and trend analysis information. No additional corrective actions are planned for this condition.

Corrective Steps Taken and Results Achieved:

- Investigations were immediately initiated to determine the root cause, extent, and effect of the concern, and to identify the corrective actions necessary to resolve the adverse conditions.

Corrective Steps That Will Be Taken And The Date When Full Compliance Will Be Achieved:

- Department Heads will communicate to supervisors their expectations on adherence to work hour limitations. This will be completed by August 30, 1997.

- The Department Heads will communicate to employees their expectations on self tracking and reporting work hour limits. This action will be completed by August 30, 1997.

- The Plant Manager will meet with the Call Superintendents to communicate expectations for them to challenge each supervisor's justification for exceeding the work hour limitations. This meeting will be conducted by August 15, 1997.

- The Plant Manager will establish a performance indicator on approved work hour deviations by August 30, 1997. This indicator will be a tool for management monitoring of authorization frequency and justification.

- The Plant Manager will develop a method to monitor exempt employee hours worked. The expectation and method will be communicated to all supervisors and managers by September 15, 1997.

- Procedure AP 13-001, Revision 2, "Guidelines for WCGS Staff Working Hours", will be enhanced to provide better guidance. This revision will be completed by August 22, 1997.

- Quality Evaluations will monitor implementation of AP 13-001 during Refueling Outage Nine. The results of this monitoring will be made available to management by November 30, 1997.

Violation 50-482/9710-03:

"Technical Specification 4.5.2.c.2 requires in part that a visual inspection be performed:(1) For all accessible areas of that containment prior to establishing CONTAINMENT INTEGRITY and (2) Of the areas affected within containment at the completion of each containment entry when CONTAINMENT INTEGRITY is established.

Contrary to the above:

1) On October 18, 1997, the licensee identified that Technical Specification Clarification 010-85 directed plant personnel to perform the required containment inspection once each day after re-establishing containment integrity rather than after establishing containment integrity each time following containment entries. The licensee implemented the clarification numerous times since the clarification was developed in 1985.

2) On May 20, 1997, containment integrity was established after three separate containment entries without the performance of the required containment inspection."

Reason for Violation:

On October 24, 1996, WCNOC identified that TSC 010-85 incorrectly allowed a violation of Technical Specification Surveillance Requirement 4.5.2.c.2. This TSC allowed for the daily performance of STS EJ-001, "Containment Inspection", versus performing the inspection after each containment entry was completed. TSC 010-85 was subsequently deleted. Following this deletion, no procedural guidance was created to define the term "containment entry", as it was expected that literal compliance to Surveillance Requirement 4.5.2.c.2 would ensure compliance. On May 21, 1997, during a forced outage, it was noted that containment inspections were not performed as required by Surveillance Requirement 4.5.2.c.2 and procedure STS EJ-001, Revision 10, "Containment Inspection". It was determined that for three time periods, during May 20, 1997, after the containment entries commenced, the containment was unmanned without inspections being performed.

During investigation and corrective action implementation for this violation, the NRC Issued Amendment 105 to the WCGS Technical Specifications. It was received on June 23, 1997. This amendment changes the requirement for Technical Specification Surveillance Requirement 4.5.2.c to daily inspection. STS EJ-001 currently requires completion of the procedure in accordance with this Surveillance Requirement.

Root cause investigation determined that neither the STS EJ-001 procedure, nor the Technical Specifications, define "containment entry". Therefore, the Shift Supervisors were left to decide what constitutes a "containment entry". The Shift Supervisor identified that he was aware of Management's expectations for literal compliance. However, the Shift Supervisor developed a non-conservative definition of "containment entry". The Shift Supervisor considered his Technical Specification interpretation as correct, without questioning other sources. This definition not challenged by other members of the crew, nor was it challenged during a recent training class on Technical Specification Literal Compliance.

The root cause of this event was determined to be inadequate program monitoring or management. The corrective actions following the concerns with the use of Technical Specification Clarifications addressed the need for literal compliance; however, Wolf Creek employees have failed to meet Operations' performance expectations when addressing literal compliance.

Corrective Steps Taken and Results Achieved:

- Licensee Event Report (LER) 97-009-01 was issued

- Status Charts provided incorrect information about performing containment inspections. These documents were initially revised to ensure compliance with Surveillance Requirement 4.5.2.c.2. However, upon the receipt of Technical Specification Amendment 105, the changes made to these documents were no longer required. Technical Specification Amendment 105 was received on June 23, 1997, and the R2 Status Charts were revised to address Amendment 105. This ensures compliance with Surveillance Requirement 4.5.2.c.2, and no further actions are required.

- The inability of the individuals involved to comply with Technical Specifications, along with the other noted occurrences of similar concerns, identifies the need for further site-wide discussions concerning the appropriate and expected use of literal compliance. This was addressed at site-wide meetings held during July, 1997.

Corrective Steps That Will Be Taken And The Date When Full Compliance Will Be Achieved:

- All Technical Specification Clarifications deleted after September, 1996, will be reviewed to ensure applicable information is captured in Operations' procedures. This review will be coordinated by Operations Support with the assistance of Licensed Operators. This review will be completed by August 12, 1997, and the appropriate procedure revisions will be completed by September 16, 1997.

- To ensure the proper completion of future containment inspections, guidance will be added to STS EJ-001 concerning the required performance and the scope of the inspection which should take place. This will be completed by August 31, 1997.

- To address the root cause of this concern, discussions of Management's Expectations and literal compliance will take place with each Shift Supervisor, Supervising Operator and appropriate members of Operations Training. These discussions will be conducted by the Manager Operations, and will be completed by August 31, 1997.

- AP 25A-100, "Containment Entry", will be revised to provide an acceptable definition of containment entry. Based on the receipt of Amendment 105, the procedure will also be revised to notify the Shift Supervisor, as required, to ensure completion of STS EJ-001 in accordance with Technical Specification Amendment 105. AP 25A-100 will be revised by August 31, 1997.

Violation 50-482/9710-06:

"Technical Specification 6.1.1 requires, in part, that procedures for personnel radiation protection be adhered to for all operations involving personnel radiation exposure.

Administrative Procedure AP 25A-001, "Radiation Protection Manual," Revision 2, Step 6.8.1, requires that personnel requiring access into the radiological controlled area be issued personnel radiation dosimetry devices which must be worn at all times within the radiological controlled area.

Contrary to the above:

1) On March 20, 1997, an engineer and a quality control inspector entered a high radiation area within the radiological controlled area without wearing the thermoluminescent dosimetry they had been issued.

2) On June 12, 1997, two mechanics entered the radiological controlled area without wearing the thermoluminescent dosimetry they had been issued."

Reason for Violation:

There were two distinct causes for these events. The first cause was inattention to detail. On-the-job distractions due to inadequate work planning distracted workers from active awareness of their dosimetry requirements and status.

The second cause was loosely defined RCA boundaries in the Access Control area and the immediately adjacent Health Physics offices.

Corrective Steps Taken and Results Achieved:

- Both individuals involved in this incident were disciplined in accordance with procedure AI 13C-001, "Standards of Conduct, Rules and Discipline". The individuals were also made aware of the company's expectations for following radiation work practices and procedures.

- The Plant Manager addressed the morning managers' meeting on July 23, 1997, and expressed his expectations for all work groups to review the Radiological Control Area (RCA) entry requirements with their personnel.

Corrective Steps That Will Be Taken And The Date When Full Compliance Will Be Achieved:

- WCNOC will monitor and challenge workers entering the RCA. This is a short term action to be implemented until further evaluation can be performed.

- Performance Improvement Request (PIR) 97-2389 has been written to address the observed decline in performance of radiation workers. The scope of this PIR includes radiation worker training, radiation worker qualifications, and personnel accountability. The corrective action plan will be generated by October 3, 1997.

- WCGS Health Physics will submit a proposed design change to be evaluated using the design change process. This design change will be submitted by January 1, 1998.